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Men with childhood sexual abuse histories: Disclosure experiences and links with mental health

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ABSTRACT

Background: There is limited research on the disclosure experiences of men who have experienced childhood sexual abuse and on how such experiences might impact mental health outcomes.
Objective: The current study described men's disclosure experiences and examined the role of disclosure characteristics on mental well-being (internalizing and externalizing behaviors, substance use, resilience).
Participants and setting: Men (N = 253) from across Canada and the U.S. were recruited through websites for males with sexual abuse histories. Men aged 18–59 years anonymously completed an online study on their sexual abuse, disclosure experiences, and mental health outcomes.
Results: Findings indicated that 77.9% of men disclosed their sexual abuse, although they waited an average of 15.4 years before sharing their experience. Once disclosed, 64.4% of the men reported a positive response (e.g., support), while 35.6% reported a negative response (e.g., blame). Regression analyses indicated that a greater delay in disclosure predicted greater externalizing behaviors ($B = .49$, $p < .05$), although this was a small effect (Cohen's $f^2 = 0.02$). Additional disclosure variables were associated with components of externalizing (aggressive and rule-breaking behaviors) and internalizing (somatic complaints) behaviors.
Conclusions: These results require replication in future studies. However, they do suggest that efforts need to be undertaken to address the barriers that hinder men from disclosing their sexual abuse and to ensure that men are supported once they disclose.

1. Introduction

There is growing attention to the reality of male childhood sexual abuse among researchers and clinicians in the field, as well as in our society more generally. Although prevalence rates show variability, a generally-accepted statistic is that 1 in 6 men have experienced sexual abuse during childhood and/or adolescence (Romano & De Luca, 2014). These rates underestimate the true scope of the problem. One review found that fewer than 1 in 4 children immediately discloses their sexual abuse (Paine & Hansen, 2002), and several researchers have noted 3–4 times as many instances of sexual abuse than are actually disclosed to family members or authorities (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Mills, Kisely, Alati, & Najman, 2016).

Non-disclosure of childhood sexual abuse at any point during one's lifetime appears to be higher in males than females (Hébert,

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Tourigny, Cyr, McDuff, & Joly, 2009; Ullman & Filipas, 2005). Males' underreporting may be partially explained by such factors as masculinity stereotypes (e.g., males should protect themselves against aggressors, sexual activity with an older female should be considered positive, males are not victims) and abuse characteristics, such as fears of being labeled homosexual if the perpetrator was also male (Alaggia, 2005; Dorahy & Clearwater, 2012; Easton, Saltzman, & Willis, 2014; Romano & De Luca, 2014; Weiss, 2010). The findings that sexual abuse is approximately 2.5–3 times higher in females than males (Briere & Elliott, 2003; Dube et al., 2005) may also make it difficult to recognize childhood sexual abuse among males. As such, child protection and health professionals may not routinely inquire about male sexual abuse and/or they may minimize its seriousness when reported (Lab, Feigenbaum, & De Silva, 2000).

1.1. What are the impacts associated with childhood sexual abuse?

There are a number of mental health pathways following childhood sexual abuse, from severe difficulties in socio-emotional well-being to resilient functioning and a host of different presentations in between that are likely to change over the course of one's lifetime. Among adult males, childhood sexual abuse has been associated with mental health difficulties that include mood, anxiety, somatic problems, and posttraumatic stress as well as problems in sexual and interpersonal functioning (Andrews, Corry, Slade, Issakidis, & Swanston, 2004; Dube et al., 2005; Easton & Kong, 2017; Holmes & Slap, 1998; Maniglio, 2009; Romano & De Luca, 2001; Spataro, Mullen, Burgess, Wells, & Moss, 2004). Men may also turn to substance use as one way of coping with maltreatment-related distress. In a systematic review of 18 studies of clinical and community based men with sexual abuse histories, Butt, Chou, and Browne (2011) found a link between sexual abuse and substance use in terms of earlier onset and greater frequency and variety of drug use.

Turning to more positive outcomes, recent reviews (including males and females) have found that not all individuals with histories of childhood sexual abuse experience mental health problems and some, in fact, exhibit resilient functioning (Domhardt, Münzer, Fegert, & Goldbeck, 2015; Marriott, Hamilton-Giachritsis, & Harrop, 2014). For example, a systematic review of quantitative studies published between 1995 and 2013 focused on resilient functioning among individuals (child, youth, adults) who experienced childhood sexual abuse (Domhardt et al., 2015). Of the 37 included studies, 10 explicitly presented rates of resilience (defined primarily as lack of psychopathology) that varied between 15–47% among adult male and female populations.

Several theoretical models have been proposed to account for the variety of childhood sexual abuse-related impacts. The ecological-transactional model (Cicchetti & Lynch, 1993) can provide a comprehensive understanding of the various ways in which individual-level factors (e.g., characteristics of the child and of the sexual abuse) can influence and be influenced by the different systems in which the child is embedded (e.g., family, school) over time to result in specific mental health outcomes unique to the individual. The complex trauma model (National Centre for Child Traumatic Stress (NCTSN), 2003; van der Kolk, 2005) overlaps with the ecological-transactional model in that both highlight the importance of relationships between children and their environments, although the complex trauma model focuses primarily on the child-caregiver relationship. It outlines the ways in which traumatic experiences within the caregiving system can interfere with key developmental processes (e.g., attachment, emotion regulation) implicated in common sexual abuse-related mental health problems, such as mood and posttraumatic stress (NCTSN; van der Kolk, 2005).

In keeping with the tenets of both the ecological-transactional and complex trauma models, there are numerous factors that can impact (and interact with other factors to indirectly impact) mental health outcomes among males who have experienced childhood sexual abuse. Such factors include, but certainly are not limited to, characteristics of the sexual abuse experience, sexual abuse disclosure experiences, the quality of the child-parent relationship, family functioning, the presence of other victimization and non-victimization adversities in the individual's upbringing, and the individual's abuse-related coping (Cutajar et al., 2010; Marriott et al., 2014; Whiffen & MacIntosh, 2005). Although a review of these factors is beyond the scope of our study, we wish to highlight several findings. First, there is evidence that childhood sexual abuse among males often co-occurs within the context of other forms of maltreatment (e.g., physical abuse; Dong, Anda, Dube, Giles, & Felitti, 2003; Edwards, Holden, Felitti, & Anda, 2003; Maikovich-Fong & Jaffee, 2010; Perez-Fuentes et al., 2013) and non-maltreatment adversities (e.g., parental substance use; Dong et al., 2003; Easton, 2012; Finkelhor, Ormrod, Turner, & Hamby, 2005; Finkelhor, Turner, Shattuck, & Hamby, 2013). Research also indicates a cumulative effect in that exposure to multiple forms of victimization is associated with increased risk for mental health difficulties (Easton, 2012, 2014; Finkelhor, Ormrod, & Turner, 2007; Garnefski & Diekstra, 1997; Ruggiero, McLeer, & Dixon, 2000). Second, there often are serious difficulties in the families of origin among individuals who experienced childhood sexual abuse. Research suggests that these individuals more frequently perceived their families as having higher conflict as well as lower cohesion and support, compared with non-abused individuals (Ramsner & McCabe, 2000; Meyerson, Long, Miranda, & Marx, 2002; Perez-Fuentes et al., 2013). These family-level difficulties have been linked with abuse-related negative outcomes in studies with women (Meyerson et al., 2002; Yama, Tovey, & Fogas, 1993) and boys and girls (Hébert, Tremblay, Parent, Daignault, & Piché, 2006).

1.2. What is the role of disclosure on childhood sexual abuse impacts?

There are many factors that may play a role in mental health outcomes following childhood sexual abuse. In the current study, we focused on the potential influence of disclosure experiences as they relate to childhood sexual abuse. To date, we know very little about men's childhood sexual abuse disclosure experiences and the way such experiences might impact short- and long-term mental health outcomes. Research generally suggests that it is rare for childhood sexual abuse to be reported to child protection or law enforcement (Easton, 2013; Frias & Erviti, 2014; Mohler-Kuo et al., 2014; Smith et al., 2000) and that men take significantly longer

than women to disclose and are, in fact, less likely to do so (Frias & Erviti, 2014; Hébert et al., 2009; Mohler-Kuo et al., 2014; O'Leary & Barber, 2008; Ullman & Filipas, 2005).

One relatively recent U.S. study has helped to increase our knowledge about the disclosure experiences of males with sexual abuse histories (Easton, 2013). In the sample of 487 adult men (average age of 50 years), findings showed that almost all (97%) disclosed their sexual abuse at some point in their lives. However, it took an average of 21 years for a disclosure to occur. Other studies have also found that the majority of men tend to wait many years before disclosing their childhood sexual abuse, if at all (Gagnier & Collin-Vézina, 2016; Holmes & Slap, 1998; O'Leary & Barber, 2008; Paine & Hansen, 2002). In Easton's (2013) U.S. study, findings also indicated that most men first disclosed their childhood sexual abuse to a spouse/partner (27%), followed by a mental health professional (20%), friend (17.6%), or parent (13.1%). There was variability in response depending on the person to whom the sexual abuse was disclosed and whether it was disclosed during childhood or adulthood. Responses included feeling believed (57.4–96.9%), supported (28.6–83.5%), and protected (30.8–48.1%). Qualitative research involving men with childhood sexual abuse has found that they were often met with mixed disclosure responses, including unsupportive reactions (Gagnier & Collin-Vézina, 2016; Sorsoli, Kia-Keating, & Grossman, 2008). Disclosure reaction can be critical to well-being. A recent systematic review found that social support by a caring and competent caregiver was among the most important variables to buffer against the potential adverse impact of sexual abuse (Domhardt et al., 2015).

There is some research suggesting an association between sexual abuse disclosure experiences and mental health outcomes; however, the findings are mixed. Several studies have indicated that disclosure is associated with healthier outcomes (Hébert et al., 2009), while others have found disclosure at the time of the sexual abuse to be related to greater psychological distress in adulthood (O'Leary & Gould, 2010). These results are not altogether surprising given the often complex circumstances that surround childhood sexual abuse (e.g., whether the perpetrator is a family member, whether other forms of victimization and/or non-victimization adversities are present) and the various reactions to a disclosure, all of which may interact with the actual act of disclosing to influence mental health functioning. For instance, disclosing one's sexual abuse can be pivotal in stopping further instances of sexual abuse, reducing feelings of shame and hyper-vigilance related to secret keeping, and creating opportunities to secure intervention services (Alaggia, 2005; Hébert et al., 2009; Vogel & Wester, 2003). In contrast, a sexual abuse disclosure might be met with disbelief and accusations of lying, minimization of the impact of the abusive experience, victim blaming, or withdrawal of family support (Alaggia, 2005; Mallory, Lyon, & Quas, 2007; Smith et al., 2000; Sorsoli et al., 2008; Ullman & Filipas, 2005). Such negative reactions have been found to be associated with a range of psychological and physical health problems among males and females (Bernard-Bonnin, Hébert, Daignault, & Allard-Dansereau, 2008; Easton, 2014; Ullman & Filipas, 2005). O'Leary and Gould (2010) found that an important variable to understanding the relationship between disclosure and greater mental health difficulties was if the person to whom the child disclosed in confidence told another individual about the sexual abuse without the child's consent. Specifically, this response to the child's disclosure, which further violated the child's trust, was associated with greater mental health difficulties.

Turning to other disclosure-related factors, some research with male and female populations has suggested that delayed disclosure is associated with greater mental health impairments in adulthood (Easton, 2013; Ullman, 2007) while earlier disclosure is associated with better mental health for some outcomes (e.g., depression) but not others (post-traumatic stress; Broman-Fulks et al., 2007). Other studies have reported opposite findings, showing earlier disclosure to be linked with greater psychological distress, explained in part by negative reactions to the disclosure (O'Leary & Gould, 2010). While most past research has focused on women, one recent study examined 487 adult men with childhood sexual abuse histories (Easton, 2014). In terms of disclosure, findings from the multiple regression analysis showed that greater number of years until disclosure predicted greater mental distress (i.e., internalizing difficulties). In addition, greater reported helpfulness of others upon sexual abuse disclosure predicted less mental distress. An important feature of this study was the inclusion of control variables, namely socio-demographics, childhood sexual abuse severity indicators, and presence of other childhood adversities (e.g., maltreatment, parental mental illness, parental substance abuse).

1.3. Study objectives

The research linking sexual abuse disclosure experiences to mental health outcomes among men has been quite limited. Given childhood sexual abuse rates in this population and the many stereotypes associated with male sexual abuse, we deemed it important to more closely examine the topic of disclosure. The study objectives were to 1) further understand the disclosure experiences of 253 adult men from Canada and the United States and 2) examine potential links between disclosure-related characteristics and mental health outcomes. We elaborated on previous work (Easton, 2013, 2014) by exploring not only internalizing outcomes but also externalizing outcomes, resilient functioning, and substance use. Similar to previous research (Easton, 2014), we made use of rigorous statistical modelling in the form of multiple regressions that controlled not only for sexual abuse characteristics but also for the presence of other victimization and non-victimization adversities, given their frequent co-occurrence with childhood sexual abuse and impacts on mental health outcomes (Andrews et al., 2004; Dube et al., 2005; Easton & Kong, 2017; Felitti et al., 1998; Finkelhor et al., 2009). Based on past, albeit limited, research, we expected most adult males in our sample to have disclosed their childhood sexual abuse experiences at some point in their lives. We also expected disclosure characteristics (e.g., length of time before disclosure, reaction to disclosure) to be associated with mental health outcomes.

2. Methods

2.1. Participants

We focused on 18–59 year old males within the community who had experienced difficult events during childhood and/or adolescence. Our recruitment efforts did not explicitly state that the study was examining men with sexual abuse histories because such an approach is likely to exclude many individuals who may not characterize their experience as abusive (Harned, 2004; Orchowski, Untied, & Gidycz, 2013). Men were recruited online across Canada and the United States via websites offering information and resources for this population (menandhealing.ca; 1in6.org). The website developers reviewed our study protocol and provided permission to post study information on their website. We also advertised through local community organizations that provide services to this population. All study procedures were approved by our University's Research Ethics Board.

Initially, 571 men accessed the online study and completed questions that inquired about sexual activity and other childhood experiences, as well as current mental health. To be included in the study, men were required to endorse having engaged in sexual activity during childhood and/or adolescence that would be deemed to meet criteria for sexual abuse. We relied on the Criminal Code of Canada (1985) to define childhood sexual abuse as any contact or non-contact sexual experience occurring before the age of 16 years with an individual in a relative position of authority, trust, or dependency (e.g. parent, coach) or sexual activity that exploits the younger person. Sexual activity was considered exploitative based on the nature and circumstances of the relationship (e.g., child age, child-perpetrator age difference). Sexual experiences occurring between the ages of 14–15 years with individuals with an age difference fewer than five years, as well as sexual experiences occurring between the ages of 12–13 years with individuals less than 2 years older and with whom there was no relationship of authority, trust, or dependency, were not considered childhood sexual abuse (Criminal Code of Canada, 1985; U.S. Department of Justice, 2014).

Following this screening procedure, 392 participants were retained. As a second screener, we eliminated any individual who was missing significant data on his childhood sexual abuse and disclosure experiences, given that these were our two primary variables of interest. This procedure resulted in a final sample of 253 men, with 97 (38.3%) from Canada and 156 (61.7%) from the United States. Table 1 shows that men had a mean age of 39.5 years (SD = 12.4). Most (41.2%) had never been married, while 39.6% were married or living with a partner. Men were primarily of Caucasian background (78.2%), and most (57.7%) had completed high school. The majority of men (81.8%) were employed outside the home. There was variability in reported household income, with the majority (65.5%) reporting less than $50,000 in Canadian funds.

Table 1
Men's Socio-Demographic Characteristics (N = 253).

Variable	%	M (*SD*)
Age		39.5 (12.4)
Marital Status (N = 245)		
Never married	41.2	
Married or living with partner	39.6	
Separated or divorced	11.9	
Widowed	0.4	
Other (not specified)	6.9	
Ethnicity		
Caucasian	78.2	
East and South Asian	9.9	
Middle Eastern	4.3	
Hispanic	2.4	
Mixed	2.4	
Black	1.6	
Indigenous	1.2	
Highest Completed Education (N = 232)		
Elementary	7.4	
High School	57.7	
University – Undergraduate	27.1	
University – Graduate	7.8	
Employment (N = 248)		
Unemployed	18.2	
Employed	81.8	
Household Income in Canadian funds (N = 139)		
Less than $9,999	9.4	
$10,000-$29,999	22.3	
$30,000-$49,999	33.8	
$50,000-$69,999	10.8	
$70,000-$89,999	10.0	
$90,000-$109,999	5.8	
Over $110,000	7.9	

Note: M = Mean; *SD* = Standard Deviation.

2.2. Materials

2.2.1. Socio-demographic questionnaire

Participants responded to questions about their age, ethnicity, income, employment, and marital status.

2.2.2. Sexual victimization survey (SVS; Finkelhor, 1979)

Participants completed a modified version of the SVS to describe up to three sexual experiences (with different individuals) before age 16. The original SVS asks participants to describe up to 12 childhood sexual experiences. Although this approach increases the likelihood of capturing all experiences, it would have made our study too lengthy and potentially caused significant participant distress related to recounting such a great number of early sexual experiences. The original SVS is divided into four sections (i.e., sexual experiences before/after age 12 with family/non-family member). However, previous studies suggest that participants find the different sections to be confusing (Shchupak, 2015). To improve clarity, we asked participants to describe up to three experiences regardless of their age of onset and/or relationship to the perpetrator. For each sexual experience, participants provided information on the type of sexual act(s), child-perpetrator relationship, age of abuse onset, frequency, duration, and disclosure experiences. For disclosure, men responded to the following questions for each sexual experience: 1) *Who have you told about the sexual experience?* followed by a list for which they could select all that applied; 2) *If you did tell someone, approximately hold old were you when you first told another person about the sexual experience?* to which participants could either provide their age or indicate they did not disclose the experience; 3) *The first time you told someone, if you told at all, how did that person react (check all that apply)?* followed by blamed you, supported you, did not believe you, ignored you, or other (describe); and 4) *Was this experience ever reported to the police or to a child welfare agency?* followed by either yes or no.

For men reporting more than one sexual abuse experience, each characteristic was coded according the greatest severity across reported sexual experience. Past studies have tended to code only the most severe experience (Bennett, Hughes, & Luke, 2000; Hulme & Agrawal, 2004; Shchupak, 2015). Although this method simplifies analyses, it does not account for the potentially significant impact of other sexual abuse experiences, and it requires a judgment on the part of the researcher about which experience is considered the most severe (e.g., age of onset, chronicity, type of sexual act). If a participant in the current study reported two sexual abuse experiences, one of which was perpetrated by an uncle for less than one month, while the other was perpetrated by a friend over many years, the duration variable was coded as "more than 1 month" and the relationship to the perpetrator variable was coded as "both family and non-family members." Greater physical invasiveness of the sexual act(s), earlier age of abuse onset, abuse by a family member, longer abuse duration, greater frequency of abuse, and the use of threat and/or physical force during the abuse experience were considered more severe, based on general conclusions from the research literature (Dube et al., 2005; O'Leary & Gould, 2010; Zink, Klesges, Stevens, & Decker, 2009) as well as the complex trauma model (van der Kolk, 2005). For our disclosure analyses, we focused primarily on the participant's first disclosure experience for the coding of several variables (e.g., length of time between sexual abuse onset and disclosure, person to whom sexual abuse disclosed). The reaction to disclosure variable was coded in this manner because we anticipated that men's first disclosure experience would be the most salient and would impact their willingness to disclose sexual abuse to other individuals in the future.

2.2.3. Adverse childhood experiences study- childhood maltreatment subscale (Felitti & Anda, 1997)

This 11-item subscale was used to assess experiences with other types of childhood maltreatment before the age of 16, namely emotional abuse, physical abuse, emotional neglect, physical neglect, and exposure to intimate partner violence. Note that we did not retain the sexual abuse items from this questionnaire given our comprehensive assessment of this maltreatment type through the SVS. Three items were added to the original subscale to examine mother-perpetrated intimate partner violence. Participants responded to each item as either present (1) or absent (0). Total scores could range from 0 to 2 for emotional abuse, physical abuse, emotional neglect, and physical neglect and from 0 to 6 for exposure to intimate partner violence.

2.2.4. Childhood non-victimization adversity

This 15-item subscale of the Childhood Trauma and Adversity Scale (Turner, Finkelhor, & Ormrod, 2006) was used to assess lifetime non-victimization adverse events. Items included non-victimization (e.g., serious illness, accident, natural disaster) and more chronic (e.g., caregiver substance abuse, bullying) adversity. Each item was rated as absent (0) or present (1), with a total score ranging from 0 to 15.

2.2.5. Adult self-report (ASR; Achenbach & Rescorla, 2003)

The ASR is a self-report measure of emotional (internalizing) and behavioral (externalizing) difficulties among 18–59 year olds. Participants responded to 126 statements over the past 6 months using a 3-point Likert scale, ranging from 0 (not true) to 2 (very true/often true). The internalizing subscale has 39 items related to anxious/depressed behavior, withdrawn behavior, and somatic complaints (e.g., *I feel that no one loves me*). The externalizing subscale has 35 items related to aggression, rule-breaking behavior, and intrusiveness (e.g., *I do things that may cause me trouble with the law*). Internalizing (externalizing) scores range from 0–78 (0–70), with higher scores indicating greater difficulties. Finally, the last three items of the ASR assess how many times per day individuals used tobacco, were drunk on alcohol, and/or used drugs in the past 6 months. Tobacco, alcohol, and drug items were standardized and summed to create a total t-score for each subscale. A mean substance use score was computed by averaging the t-scores for the tobacco, alcohol, and drug scales, with higher scores indicating greater substance use. In our sample of males, the mean score was 61.8 (SD = 10.2) for internalizing difficulties, 51.8 (SD = 11.0) for externalizing difficulties, and 53.7 (SD = 15.2) for mean

substance use score. The internal consistencies were good for the internalizing (α = .86) and externalizing (α = .82) scales and for the substance use mean score (α = .84).

2.2.6. Connor-Davidson resilience scale - 10 (CD-RISC-10; Connor & Davidson, 2003)

The 10-item version of the CD-RISC assesses past-month resilient functioning by way of coping ability, perseverance, a sense of purpose/control, and pride in one's accomplishments (e.g., *I can deal with whatever comes my way*). Participants rated each item along a 5-point Likert scale from 0 (not true at all) to 4 (true nearly all the time). Items were summed to produce a total score, which could range from 0 to 40 and where higher scores reflect greater resilient functioning. Our sample's mean score was 21.9 (*SD* = 8.2), and the internal consistency was excellent (α = .90).

2.3. Procedure

Once individuals accessed the online study through Fluid Survey, eligibility criteria were assessed. Individuals were required to: self-identify as male; be between 18–59 years; be fluent in English; be currently residing in Canada or the United States; and have had a sexual experience before the age of 16. Participants who did not meet all criteria were forwarded to a webpage thanking them for their interest and explaining that they were not eligible. Eligible participants provided consent online and were informed that they could withdraw from the study at any time without penalty. Participants anonymously completed socio-demographic questions and then the following: SVS (Finkelhor, 1979); childhood maltreatment subscale from the Adverse Childhood Experiences Study (Felitti & Anda, 1997); non-victimization adversity subscale of the Childhood Trauma and Adversity Scale (Turner et al., 2006); ASR (Achenbach & Rescorla, 2003); and CD-RISC-10 (Connor & Davidson, 2003). Note that this study was part of a larger one that included several additional questionnaires. Upon completion of the questionnaires, participants were provided with a sensory grounding exercise and a list of mental health resources that they could contact. Males were also invited to enter a draw for one of four $50 Visa gift cards.

2.4. Data analyses

All study variables were examined for missing data prior to analyses, and the rate was found to be 4.8%. Imputation techniques are not suggested for participants missing more than 5% of their overall data (Tabachnick & Fidell, 2007) or those with 20% or more missing items on a scale (Mazza, Enders, & Ruehlman, 2015). Given our low number of missing data, we used Expectation Maximization instead of mean substitution or multiple imputation (Dong & Peng, 2013). After imputation, variables were examined for outliers. We identified one univariate outlier on the non-victimization adversity scale due to a participant's high standardized score ($z > 3.29$) so his raw score was bootstrapped to the value of the next highest score on the scale (Tabachnick & Fidell, 2007). When the standardized scores were again computed, this value ceased to be an outlier. There were no multivariate outliers according to the Mahalanobis distance ($p < .001$).

Once the data were cleaned and imported from Fluid Survey into SPSS 24.0, descriptive analyses were conducted to understand childhood victimization and non-victimization experiences as well as characteristics of their sexual abuse disclosure. We conducted Pearson's correlations among all study variables to assess the nature of any statistically significant associations. Then, a series of linear regressions examined the extent to which disclosure characteristics predicted mental health outcomes, specifically internalizing difficulties, externalizing difficulties, substance use, and resilient functioning. The regressions controlled for childhood sexual abuse characteristics (e.g., relationship with the perpetration, duration) as well as other victimization and non-victimization adversities. Note that preliminary analyses indicated that regression assumptions of multivariate normality, multicollinearity, linearity, and homoscedasticity were met. Finally, we calculated effect sizes for each regression using Cohen's f^2. According to Cohen's (1988) guidelines, $f^2 \geq 0.02$, $f^2 \geq 0.15$, and $f^2 \geq 0.35$ represent small, medium, and large effect sizes, respectively.

3. Results

3.1. Childhood victimization and non-victimization experiences

Men had the opportunity to provide information on a maximum of three different sexual experiences during childhood or adolescence which were then coded for whether they met sexual abuse definitional criteria. On average, men reported 2.2 (SD = 0.8) sexual abuse experiences. Table 2 shows that 28.9% of men reported one experience; 24.9% reported two experiences; and 46.2% reported three experiences. This table presents information across all the reported experiences. They described a range of sexual acts during childhood, with fondling being the most frequent (83.8%) followed closely by non-contact forms of sexual abuse (e.g., perpetrator showing genitals to the child; 78.3%). Importantly, almost half the men (47.4%) reported oral-genital contact, and more than one-third (36.0%) reported having experienced anal penetration. The average age of sexual abuse onset was 8.5 years (*SD* = 3.7 years), and the majority (64.4%) identified the perpetrator to be a non-family member (e.g., stranger, family friend, priest/religious figure). More than half of the men (52.2%) reported that the sexual abuse experience occurred once or twice and that the duration was longer than one month (69.6%). Finally, the majority of men (89.3%) reported being threatened and/or physically forced to engage in sexual behaviors by their perpetrators.

For other types of childhood abuse, Table 2 shows that about 6 in 10 men reported having also experienced neglect (62.2%), emotional abuse (60.9%), and/or physical abuse (57.7%). About 1 in 4 men (23.3%) reported having been exposed to intimate

Table 2
Men's Childhood Sexual Abuse Characteristics (N = 253).

Variable	%	M (*SD*)	Range
Number of Experiences			
1	28.9		
2	24.9		
3	46.2		
Types of Sexual Acts			
Non-contact	78.3		
Fondling	83.8		
Oral-genital	47.4		
Penetration	36.0		
Pornography	13.0		
Age of Onset		8.5 (3.7)	0–15
Relationship to Perpetrator			
Family	25.7		
Non-family	64.4		
Both family and non-family	9.9		
Frequency of Abuse			
Once or twice	52.2		
Between 3-10 times	22.5		
Between 11-25 times	10.7		
Between 26-50 times	7.5		
More than 50 times	7.1		
Duration of Abuse			
Less than one month	30.4		
Longer than one month	69.6		
Forced/Physically Threatened by Perpetrator	89.3		
Other Types of Childhood Abuse			
Physical abuse	57.7		
Emotional abuse	60.9		
Neglect	62.2		
Exposure to intimate partner violence	23.3		
Non-victimization Adversity		4.4 (2.5)	0–15

Note: M = Mean; *SD* = Standard Deviation.

partner violence. The mean number of non-victimization adversities reported by men during their childhood and adolescent years was 4.4 (*SD* = 2.5). The most commonly reported adversities were: bullying or teasing about weight, physical disability, acne, or wearing glasses (61.3%); witnessing caregivers often arguing, yelling, and being angry with one another (61.3%); loss of a loved one (54.2%); and a serious alcohol or substance use by a family member (41.1%).

3.2. Childhood sexual abuse disclosure

The majority of men (77.9%) disclosed at least one childhood sexual abuse experience. For those who reported multiple abuse experiences, the majority (84.6%) also disclosed all reported experiences. Table 3 indicates that the mean age of first disclosure was 23.7 years (*SD* = 13.1), with the time lapse between age of sexual abuse onset and age of first disclosure being, on average, 15.4 years (*SD* = 13.9). Most men (57.7%) only made their first disclosure as an adult, while 25.7% first disclosed during adolescence and 16.6% during childhood. On average, men disclosed their childhood sexual abuse to 2.3 (*SD* = 1.4) individuals. In examining men's first disclosure experience, most indicated having shared their sexual abuse with a friend (44.7%), followed by their mother (22.5%) or father (16.2%). In terms of the reaction to their first childhood sexual abuse disclosure, the majority of men (68.0%) indicated that the response was supportive. In contrast, 7.5% reported being blamed, 10.7% were ignored, and 13.8% were not believed. Finally, almost 8 in 10 men (77.5%) noted that their first disclosed sexual abuse experience was not reported to authorities, such as child welfare or the police.

3.3. Disclosure predictors on mental health outcomes

Prior to regression analyses, we conducted simple bivariate correlations among all study variables. Table 4 shows that for the disclosure variables, greater time lapse between the age of sexual abuse onset and the age of first disclosure was associated with greater externalizing behaviors ($r = .15$, $p < .05$) and greater substance use ($r = .14$, $p < .05$). There were also significant associations in the expected direction between victimization-related variables (i.e., childhood sexual abuse severity, number of other maltreatment types, number of adversities) and the four mental health outcome variables. Turning to the disclosure variables, older

Table 3
Childhood Sexual Abuse Disclosure Characteristics (N = 253).

Variable	%	M (*SD*)	Range
Age of First Disclosure		23.7 (13.1)	3–55
Before 12 years	16.6		
Between 13-18 years	25.7		
After age 18 years	57.7		
Time Between Abuse Onset and First Disclosure (years)		15.4 (13.9)	
Individuals to Whom Abuse was Disclosed		2.3 (1.4)	
Mother	22.5		
Father	16.2		
Sibling	12.6		
Community member (Teacher)	4.0		
Friend	44.7		
Disclosure Reaction			
Supportive	68.0		
Blamed	7.5		
Ignored	10.7		
Did not believe	13.8		
Disclosed to Authorities			
Yes	22.5		
No	77.5		

Note: M = Mean; *SD* = Standard Deviation.

Table 4
Bivariate Correlations Among Study Variables.

Variable	1	2	3	4	5	6	7	8	9	10
1. Age of First Disclosure	–									
2. Disclosure Reaction	.23**	–								
3. Number of Individuals to Whom Abuse Disclosed	−.03	−.03	–							
4. Time Between Abuse Onset and First Disclosure	.82**	.16*	.03	–						
5. Childhood Sexual Abuse Severity	−.05	−.09	.19**	.10	–					
6. Number of Other Maltreatment Types	−.03	−.18*	−.03	.04	.25**	–				
7. Number of Non-Victimization Adversities	−.11	−.07	.04	−.11	.09	.49**	–			
8. Resilient Functioning	−.09	−.05	.02	−.06	−.20**	−.12	−.02	–		
9. Internalizing Difficulties	.03	.02	.03	.08	.14*	.18**	.10	−.37**	–	
10. Externalizing Difficulties	−.14	-.07	−.06	.15*	.12	.21**	.18*	−.25**	.59**	–
11. Substance Use Difficulties	−.13	-.09	−.02	.14*	.08	.23**	.12	−.26**	.69**	.78**

*p < .05 **p < .01 ***p < .001.
[a] Reference group is unsupportive reaction (blame, ignore, disbelief).
[b] Childhood sexual abuse severity was a collapsed variable along a 5-point scale, where participants received 1 point for each of the following: abuse lasting longer than one month; abuse onset prior to age 12; family member perpetrator; abuse that involved physical contact beyond fondling; and perpetrator's use of physical violence or threat of violence.

age of first disclosure was significantly associated with a more supportive disclosure reaction ($r = .23$, $p < .01$) and with a greater time lapse between abuse onset and first disclosure ($r = .82$, $p < .01$). Also, a greater time lapse between abuse onset and first disclosure was associated with a more supportive disclosure reaction ($r = .16$, $p < .05$). Finally, there were a number of significant correlations among the outcome variables in the expected direction. Internalizing, externalizing, and substance use problems were positively associated with one another and negatively associated with resilience.

Table 5 presents the regression analyses for potential sexual abuse disclosure predictors on the mental health outcomes. Note that we did not focus on the results for the control variables. Findings indicated that one disclosure variable showed a statistically significant relationship with a mental health outcome. Specifically, the time lapse between age of abuse onset and age of disclosure significantly predicted externalizing behaviors (B = .49, $p < .05$), even after controlling for sexual abuse severity and co-occurring child maltreatment and non-victimization adversity. This variable accounted for 2.2% of the variance in externalizing problems, which equated to a small effect ($f^2 = 0.02$). Relationships between disclosure variables and internalizing problems, substance use, and resilient functioning were not significant.

Given that internalizing and externalizing difficulties represent broad categories, we examined specific subscales. The three internalizing subscales include anxious/depressed, withdrawn, and somatic complaints. When we re-ran the regression analyses with the disclosure and control variables, there was one statistically significant finding. The greater the number of individuals to whom the sexual abuse was disclosed, the lower the number of somatic complaints (B = −.15, $p < .05$) including such symptoms as headaches and fatigue. This variable accounted for 1.8% of the variance in somatic complaints, which equated to a small effect ($f^2 = 0.02$). To examine whether reactions to the first disclosure could be a moderator in this relation, we tested an interaction effect but the finding was not significant.

Table 5
Association Between Disclosure Variables and Mental Health Outcomes (N = 253).

	Internalizing		Externalizing		Substance Use		Resilience	
Variables	B	(SE)	B	(SE)	B	(SE)	B	(SE)
Disclosure								
Age of disclosure	.12	(.23)	.42	(.26)	.11	(.29)	−.15	(.21)
Disclosure reaction	−.84	(1.14)	−.53	(1.27)	−1.10	(1.46)	.93	(1.07)
Number of individuals to whom abuse disclosed	.00	(.04)	.00	(.02)	.00	(.02)	.00	(.02)
Time between abuse onset and first disclosure	.15	(.22)	.49*	(.25)	−.18	(.28)	.08	(.20)
Controls								
Childhood sexual abuse severity	.12**	(.75)	1.10	(.84)	.59	(.94)	−1.15	(.70)
Number of other maltreatment types	.83	(.65)	.63	(.72)	1.51	(.80)	−.34	(.60)
Number of non-victimization adversities	.19*	(.35)	.51	(.38)	.28	(.44)	−.23	(.32)
R^2	.07		.09		.03		.04	

Note. B = unstandardized estimate; SE = standard error.
*p < .05 **p < .01 ***p < .001.
[a] Reference group is unsupportive reaction.
[b] Childhood sexual abuse severity was a collapsed variable along a 5-point scale, where participants received 1 point for each of the following: abuse lasting longer than one month; abuse onset prior to age 12; family member perpetrator; abuse that involved physical contact beyond fondling; and perpetrator's use of physical violence or threat of violence.

Turning to externalizing difficulties, the three subscales include aggressive, rule-breaking, and intrusive behaviors. Regression results (with control variables) for each of these subscales indicated that the greater the number of individuals to whom the sexual abuse was disclosed, the lower the number of aggressive behaviors ($B = -.16$, $p < .05$) and the lower the number of intrusive behaviors ($B = -.19$, $p < .05$). This predictor variable accounted for 2.8% of the variance in aggressive behaviors ($f^2 = 0.03$) and 3.7% of the variance in intrusive behaviors ($f^2 = 0.04$). Finally, results from the controlled regression model indicated that a greater time lapse between sexual abuse onset and age of first disclosure significantly predicted more rule-breaking behaviors ($B = .41$, $p < .05$), and earlier age of first disclosure predicted fewer rule-breaking behaviors ($B = -.36$, $p < .05$). These variables accounted for 3.3% ($f^2 = 0.03$) and 2.1% ($f^2 = 0.02$) of the variance in rule-breaking behavior. To examine whether reactions to the first disclosure could be a moderator in these two relationships, we tested interaction effects but again the findings were not significant.

4. Discussion

This study described the sexual abuse disclosure experiences of 253 adult men and examined links between disclosure characteristics and various mental health outcomes, namely internalizing and externalizing behaviors, substance use, and resilient functioning. The majority of men (7 in 10) reported more than one sexual abuse experience while growing up, with the abuse typically starting during middle childhood (M = 8.5 years). Most (6 in 10) identified perpetrators as being non-family members who engaged them in a range of sexual activities, many of which were invasive (e.g., penetration). It should also be noted that these men's childhood sexual abuse experiences most often occurred alongside other types of maltreatment (most notably neglect and physical/emotional abuse) as well as non-maltreatment adversities (e.g., bullying, family dysfunction). These findings underscore results from numerous studies which suggest that experiences of multiple victimization appear to be the norm, rather than the exception, among children with maltreatment histories (Andrews et al., 2004; Dube et al., 2005; Easton & Kong, 2017; Felitti et al., 1998; Finkelhor, Ormrod, Turner, & Holt, 2009)

Turning to disclosure experiences, our results were in line with expectations in that the majority of men (about 8 in 10) had told someone about their childhood or adolescent sexual abuse. This finding is consistent with that of previous research by Easton (2013), although the rate of disclosure in that study's sample was even higher (97%). This difference may be partially explained by the fact that men in Easton's (2013) study were about 10 years older than those in the current study and as such, they would have had a greater number of years during which to disclose. Men in the current study reported that their first disclosure occurred during early adulthood (M = 24 years) and that they had waited about 15 years before telling someone about their childhood sexual abuse. This prolonged time lapse between sexual abuse onset and disclosure is consistent with past, albeit limited, research (Easton, 2013) and highlights the many multi-level factors (e.g., nature of the sexual abuse, family circumstances, societal norms) that might prevent men from telling someone about their victimization.

Men in our study reported mixed reactions to their first disclosure, with about 7 in 10 indicating a supportive response while 3 in 10 an unsupportive response (i.e., blame, disbelief, ignoring). This finding is consistent with past qualitative findings (Gagnier & Collin-Vézina, 2016; Sorsoli et al., 2008) but not with Easton's (2013) quantitative study, which found primarily positive disclosure reactions. This difference may be a function of the individual to whom the disclosure was made, which was primarily a spouse for men in Easton's (2013) study but a friend for men in our study. Additional research is warranted but our findings suggest the importance of informing individuals about helpful ways to respond to a sexual abuse disclosure, especially because such responses have been found to be linked with mental well-being (Domhardt et al., 2015).

Turning to the potential links between disclosure characteristics and mental health, findings partially supported our hypotheses because there were only a few significant links (and none with the outcomes of resilience or substance use). Moreover, disclosure reaction did not emerge as a statistically significant predictor of mental well-being. The limited significant findings, however, should not be too surprising given that we only examined men's first disclosure experience, and they were asked to check off which reactions they experienced. Men may have experienced other more salient disclosure experiences after their first disclosure. It may have been more helpful to have men think about their disclosure experiences in general and rate these experiences on a scale from helpful to not helpful or to have them provide a qualitative description of their disclosure experiences as males were limited by the response set provided in our questionnaire. Moreover, we controlled for a number of important factors in our analyses (i.e., maltreatment- and victimization-related adversities), which may have limited the number of significant findings.

Consistent with most past findings (Broman-Fulks et al., 2007; Easton, 2013, 2014; Ullman, 2007), our study indicated that a *greater delay in disclosing sexual abuse* was related to greater externalizing behavior problems more generally and rule-breaking behavior more specifically. Such a time delay means many more years of men living with the stigma and shame that is often associated with sexual victimization (Easton, 2013) and not accessing supports, whether informal or formal (e.g., intervention services), to address sexual abuse-related impacts. In addition, there may be valid reasons for men delaying disclosure of their sexual abuse experience (e.g., social isolation, family dysfunction, lack of supportive individuals), and these factors may compound sexual abuse impacts to influence mental health outcomes. Our study also found that *disclosing to a greater number of individuals* was related to fewer somatic symptoms (component of internalizing behavior problems) as well as fewer aggressive behaviors and intrusive behaviors (both components of externalizing behavior problems). There is no past research to which we can compare this finding; however, one might speculate that the greater the number of individuals to whom men disclose, the greater the chances of securing a supportive response that contributes to better mental well-being. These statistically significant findings were found to have small effect sizes. However, it is our opinion that they are nonetheless meaningful because they can have significant consequences (Ellis, 2010). For example, waiting to disclose one's childhood sexual abuse can result in years of feeling isolated and stigmatized, which can undoubtedly impact well-being (such as externalizing behaviors in our current study). Moreover, the small effect sizes can accumulate into larger effects (Ellis, 2010). For example, in line with the complex trauma model, waiting to disclose can impact developmental processes (e.g., attachment relationships, sense of self as worthwhile individual, sense of self-efficacy) to result in serious longer-term impairments in well-being and functioning.

4.1. Limitations and future research directions

First, we used a convenience sampling approach whereby men were recruited from websites offering support for childhood sexual abuse. As such, findings may not reflect the experiences of men who do not actively seek out support or who may not consider their experiences to have been abusive. Moreover, there may have been increased bias toward statistically significant findings (Type 1 error), although we tried to address this possibility by also calculating effect sizes. Second, we only asked men to report on a maximum of three childhood sexual abuse experiences. Men may have had additional sexual abuse experiences that were missed and for which disclosure information was not provided. Third, while we examined a number of mental health outcomes, there may be additional ones which could be examined with respect to disclosure and which may have resulted in higher effect sizes. In keeping with the complex trauma model, for instance, it would seem important to examine disrupted attachment relationships and emotion regulation difficulties (van der Kolk, 2005). Fourth, the analyses were based on cross-sectional data so conclusions around temporal ordering and causality cannot be made. Finally, the retrospective nature of the data may have been prone to recall bias and to some inaccuracy due to the passage of time. The current study was based on men's responses to questionnaires. It would be important for future research to complement this method with a qualitative approach that includes interviews with men about their disclosure experiences. It would seem important to examine disclosure experiences in greater detail to understand, for example, the barriers that keep men from disclosing their childhood sexual abuse at the time of occurrence as well as the way events following a disclosure might impact mental well-being.

5. Conclusion

This study added to the limited research on male childhood sexual abuse in general and on disclosure experiences more specifically. One important finding was that men often waited many years and suffered in silence before disclosing their sexual abuse to a trusted individual. This finding suggests that mental health clinicians must inquire about childhood sexual abuse as part of their routine practice in providing services to men and boys (Alaggia & Millington, 2008; Easton & Kong, 2017; Gagnier & Collin-Vézina, 2016; Sorsoli et al., 2008). This finding also suggests that we need to keep addressing those barriers that keep men from sharing their histories of sexual abuse, with such efforts involving public education campaigns that highlight the frequency of male childhood sexual abuse and debunk its many misconceptions. These education efforts also need to be more targeted to those individuals to whom disclosures might be made (e.g., parents, teachers) so that disclosures are met with helpful responses that involve supporting, believing, and advocating for the young person (Paine & Hansen, 2002). Such responses might not only be critical to males' sexual abuse-related adjustment but may also help to promote earlier disclosures. For earlier disclosures, telling someone about the sexual abuse sooner was associated with better mental health. This finding again reinforces the importance of tackling the multi-level societal, familial, and personal obstacles (Sorsoli et al., 2008) that may render a sexual abuse disclosure so difficult for men. Our findings also suggested that reaching out to a number of individuals about one's sexual victimization was helpful for men, perhaps because it lowered the stigma surrounding male childhood sexual abuse and helped secure needed social supports. As such, it may be

important to encourage men to keep reaching out to trusted individuals about their sexual abuse experiences since social support has been consistently found to be linked with better mental health (Domhardt et al., 2015).

Author contributions

All authors conceived the study design. M. Ressel and J. Lyons collected the data. J. Moorman conducted the data analyses. E. Romano and J. Moorman analyzed the findings and took the lead in writing the article. All authors were involved in editing the article.

Declarations of interest

None.

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